

Past Medical History and Symptoms & Illnesses

Full legal name (please print in ink throughout this form)

Date

Please check the box if you have experienced any of the following in the past 5 years.

Past Medical History

- | | |
|-------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Coronary heart disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Peptic ulcer |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Respiratory disorder |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disorder |
| | <input type="checkbox"/> Urinary tract infection |

Symptoms & Illnesses

Weight _____ lbs Height _____

- | | | |
|--------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Corrective lenses | <input type="checkbox"/> Difficulties in speech | <input type="checkbox"/> Weight change |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Memory lapses or loss | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Motor disturbances | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Other Eye Symptoms | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Abnormal appetite |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Other Neurological Symptoms | <input type="checkbox"/> Other Constitutional Symptoms |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Pain in the arms | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Pain in the leg | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Other Otolaryngeal Symptoms | <input type="checkbox"/> Other Musculoskeletal Symptoms | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Chest pain/discomfort | <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fast heart rate | <input type="checkbox"/> Easy bruising tendency | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Other Cardiovascular Symptoms | <input type="checkbox"/> Other Hematologic Symptoms | <input type="checkbox"/> Black/bloody stools |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Depression | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other Gastrointestinal Symptoms |
| <input type="checkbox"/> Other Pulmonary Symptoms | <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Pain w/urination |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Feeling restless/agitated | <input type="checkbox"/> Bloody urine |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Loss of control (leaking) |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Other Psychological Symptoms | <input type="checkbox"/> Urination at night |
| | | <input type="checkbox"/> Other Genitourinary Symptoms |